

Assessing Experiences and Responses of Crime Victims¹

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This paper reviews strategies and methods for assessing crime victims with an emphasis on assessments for clinical purposes. In terms of outcomes, this paper primarily focuses on assessing posttraumatic symptoms of PTSD, dissociation, and traumatic grief as these are all quite disabling and may be mediators of other responses. Additional topics reviewed include reasons to assess experiences and responses of crime victims, issues to bear in mind when conducting assessments for different purposes, considerations for use of various sources of information about a client, characteristics of measures and of clients to take into account when selecting measures, recommended domains of experiences and symptoms to assess, and suggestions about the process of administering measures and conducting therapeutic assessments.

KEY WORDS: assessment; trauma; traumatic experiences; trauma responses; self-report measures; interviews.

Recent studies of adult and child crime victims demonstrate the adverse psychological consequences of crime victimization (Berman, Kurtines, Silverman, & Serafini, 1996; Boudreaux, Kilpatrick, Resnick, Best, & Saunders, 1998). Crime victim status has been found to be associated with a number of psychological disorders, including posttraumatic stress disorder (PTSD), major depressive episode, complicated or traumatic grief, agoraphobia, obsessive-compulsive disorder, social phobia, and simple phobia. Of these disorders, PTSD has been thought to play a pivotal role in responses to crime. Regression analyses have indicated that PTSD may be an important mediating variable for other psychopathology (Boudreaux et al., 1998). In other words, crime victims who develop PTSD

are at risk for developing other psychological disorders as well.

Crime victims are at risk for developing PTSD because many crimes constitute traumatic stressors. The DSM-IV diagnostic criteria for PTSD defines a traumatic event as one that “involves actual or threatened death or serious injury or a threat to the physical integrity of self or others” and a response of “intense fear, helplessness, or horror” (American Psychiatric Association, 1994, pp. 427–428). Carlson and colleagues have described an alternative definition of traumatic experiences as events that are so sudden, uncontrollable, and extremely negative that they produce overwhelming fear (Carlson, 1997; Carlson & Dalenberg, 2000). Many crimes meet these definitions, and research on many types of crime has established that crime experiences can cause PTSD. Crimes of different intensities and different levels of threat are likely to produce different rates of PTSD. For example, assaultive violence has been found to produce PTSD in 21% of those exposed (Breslau et al., 1998) and in 48–50% of female rape victims (Foa, 1997; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Research has also shown that certain characteristics of crime experiences such as perceived life threat, injury, and sexual penetration

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are associated with the development of PTSD in crime victims.

Even when a crime is not sufficiently sudden, uncontrollable, or negative to constitute a traumatic stressor, it may still have many negative psychological consequences. Challenges to assumptions about the benevolence of the world and the trustworthiness of others have been identified as a major cause of the negative psychological effects of events such as crimes (Janoff-Bulman, 1992; Newman, Riggs, & Roth, 1997). When crime victims lose faith in their beliefs that the world is a benevolent place and that they can trust other people, but still believe that there is a reason why bad things happen, they often develop problems with depression, anxiety, and anger.

Why Assess Traumatic Experiences and Responses of Crime Victims?

There are a number of reasons why it is important to assess the traumatic experiences and responses of crime victims. First, a systematic assessment of a crime victim's trauma history, including crime victimization history, will provide valuable information about the occurrence of early or multiple traumas or repeat victimization. Multiple traumas and repeat victimization are very important to know about because the effects of traumatic events can be cumulative (Bremner et al., 1992; Dancu, Riggs, Hearst-Ikeda, Shoyer, & Foa, 1996; Follette, Polusny, Bechtle, & Naugle, 1996). A recent large-scale epidemiological study of trauma experiences and PTSD found an association between previous exposure to a traumatic event and increased risk of PTSD after a second trauma (Breslau, Chilcoat, Kessler, & Davis, 1999).

Assessing the responses of crime victims will identify the major psychological symptoms of crime victimization rapidly, so that appropriate treatment can begin. Victims will be helped most if they can be treated before their symptoms become entrenched. And because PTSD following a crime can lead to many secondary responses, it is important to intervene before these begin to accumulate.

A careful assessment helps the clinician to identify the symptoms that are the most distressing and disabling for a particular crime victim. Because different symptoms often require different treatment strategies, identification of the most pressing symptoms is important to treatment planning. Without a systematic assessment, it could be easy to be mistaken about the central therapeutic issues because crime victims who are traumatized often

develop other symptoms that are secondary to and associated with the crime event. For example, interpersonal problems might develop secondary to PTSD symptoms following a rape. These interpersonal problems might be quite pressing and should certainly be attended to, but they can also divert attention from a posttraumatic response that needs to be treated.

Another reason to carefully assess crime victims is to identify potential preexisting or comorbid mental illnesses. The presence of comorbid disorders can influence trauma responses or how a particular client would respond to treatment. For example, a severely depressed client may be too apathetic and withdrawn to engage in treatment. Clients with preexisting personality disorders generally require treatment strategies adapted to their interpersonal styles.

Assessments can provide valuable information about the general role of crime experiences in a client's condition. The connection between current symptoms and crime often has important implications for treatment. For example, a client's chronic pain following a crime in which she was injured may be maintained or exacerbated by unresolved emotions relating to the trauma. In such a case, attention to resolving feelings related to the trauma may be necessary before the pain symptoms can be effectively addressed. Another client's alcohol abuse problems might be a function of efforts at avoidance of intrusive crime-related thoughts and feelings. Successful treatment of this client's alcohol problem may not be possible until intrusion symptoms are under control.

Detailed trauma history assessments can also clarify connections between specific aspects of crime events and specific current problems. By supplying important details, a trauma history assessment will aid in prediction and control of symptoms as well as in implementing treatment interventions. For example, details about crime experiences helps the clinician to identify cues that trigger traumatic reactions for a particular client. A man who was shot by a young Hispanic man later became angry and anxious when he sees a neighbor and his friends—all young Hispanic men—hanging around in the yard next door. Although such a connection may seem obvious to the therapist, the link may be outside of the client's conscious awareness. In this way, identification of traumatic cues through knowledge of crime experiences allows for greater prediction and control of crime-related reactions. Identifying traumatic cues can also be useful in the development of treatment interventions. For example, trauma cues can provide content for developing anxiety hierarchies as part of behavioral techniques such as systematic desensitization.

Purpose of the Assessment

Strategies for assessing crime victims are likely to vary depending on the purpose of the evaluation. Because evaluations for research, forensic, and clinical purposes often call for different measures and interview methods, it is important to consider how the information will be used. Some of the issues involved in selecting measures for research and forensic use are briefly described in the following section, but the remainder of the paper focuses primarily on assessments of crime victims for clinical purposes.

Research Use

When measuring aspects of crime experiences and responses for empirical studies, in addition to using measures that have been standardized and validated, it is usually preferable to use measures that quantify the variables being studied. For example, although supplementing quantitative data with qualitative data can aid in interpretation, most researchers can do more fruitful analyses of data representing frequency and intensity of particular symptoms than of qualitative data, such as descriptions of intrusive thoughts. Researchers also often favor self-report measures over interviews because self-report measures take far less professional time and expertise to administer.

In the early 1990s, measurement of traumatic experiences such as crimes became an increasingly thorny issue for researchers as the validity of self-reports and retrospective reports of traumatic experiences were challenged. Unfortunately, research on the accuracy of retrospective reports is extremely difficult to conduct, so definitive findings in this area are limited. The available research tends to support the accuracy of the central details of self-reports and retrospective reports of traumatic events (Christianson, 1992; Christianson & Loftus, 1987). Recent studies of retrospective reports of childhood abuse events seem to indicate that we should be as or more concerned about underreporting as a result of lack of recall for traumatic events as we should be about misreporting or overreporting (Briere & Conte, 1993; Widom, 1989; Williams, 1995). For these reasons, researchers collecting retrospective reports of crime experiences will want to choose measures that are designed to maximize the accuracy of reports, but they must remember that retrospective reports relating may not be inaccurate. Those interested in a detailed discussion of measurement of trauma and trauma responses for research should see Solomon, Keane,

Kaloupek, and Newman (1996); Norris and Riad (1997); and Newman, Kaloupek, and Keane (1996).

Forensic Use

There are numerous situations that call for assessment of crime experiences and responses in forensic or legal contexts. The most common of these include both the assessment of responses to crime when someone sues for damages or seeks disability or other compensation relating to a crime and assessment of the experiences of a child to determine if a crime occurred or had negative psychological effects. In such forensic contexts, clinicians need to be especially scrupulous about their assessment strategies because in legal contexts, the index of suspicion for malingering tends to be high. Particularly when monetary redress for the emotional effects of a crime are sought, lawyers for the party being sued or those who conduct disability exams may look for reasons to discredit assessments that find evidence of traumatization resulting from a crime. Forensic assessment of crime experiences is also particularly relevant in criminal cases for mitigation of death penalty and other serious sentencing options. Criminal defendants often have extensive histories of childhood abuse and adult interpersonal trauma that can play a role in their subsequent criminal behavior. Clinicians conducting forensic assessments should choose measures with well-established reliability and validity and those that allow collection of the most detailed information about symptoms and crime experiences. For instance, a measure that assesses frequency and severity of each PTSD symptom as well as inquiring about specific examples would be better than a brief self-report measure that yields only one rating of frequency per symptom. Clinicians conducting forensic assessments will likely want to seek corroboration of symptom and experience reports from any official records and collateral sources available, though this is not always done or recommended for clinical assessments.

Those working in a forensic context on behalf of crime victims (e.g., a crime victim advocate) should be cautious about assessing victims' symptoms and past trauma history because information of this kind could potentially be used against the victim. For example, it is not unusual for a husband who is charged with battering his wife to later contest child custody on the grounds that his victim has psychiatric symptoms and is therefore an unfit parent. Crime victim advocates should therefore be aware of the limits on the confidentiality of any information they gather about clients and should explain these limits and potential associated risks to clients before conducting assessments.

Perhaps the most challenging type of forensic assessment is the evaluation of children who might have been abused. Lipovsky (1992) has noted that evaluation of children to assess abuse often means balancing the sometimes conflicting need to obtain information in order to comply with reporting laws and the need to provide a therapeutic environment for the child. Because conducting forensic assessments of the effects of crime experiences is complex and beyond the scope of this research, clinicians should seek more information on forensic assessments before undertaking such evaluations. Good places to start include Pitman and colleagues (1996), Resnick (1998), Armstrong and High (1999), Keane (1995), Quinn (1995), Simon (1995), and the practice guidelines of the American Professional Society on the Abuse of Children (1995a, 1995b, 1995c).

Clinical Use

Therapists evaluating crime victims for clinical purposes will have a different set of needs than those conducting research or forensic assessments. Compared to the researcher and forensic assessor, clinicians are usually somewhat less concerned with obtaining detailed quantitative information about experiences and symptoms. For example, most clinicians will not feel the need to give a measure to every crime victim they see that requires precise quantification of the frequency and intensity PTSD symptoms. They might be more likely to use a very brief checklist to identify quickly those clients with trauma-related symptoms, and to conduct detailed evaluations of PTSD for diagnostic and treatment planning purposes for those clients only. Clinicians might also use measures of prominent symptoms over the course of treatment to track progress, showing clients their clinical gains and identifying symptoms that are refractive to treatment. Clearly, brief self-report scales would be most practically useful for this purpose.

Clinicians are also usually more interested than researchers and forensic assessors in obtaining qualitative information about crime experiences and responses. Subjective, qualitative details about events such as what was most distressing to the client about the crime and the meaning of the event will be needed to plan and provide appropriate treatment for a client. Detailed structured or unstructured interviews are likely to be the most effective ways to gather this kind of information.

Although clinicians are generally less concerned about gathering quantitative information and more interested in gathering qualitative information, they should always include scientifically validated measures in their

assessments. This is because it is important to be as sure as possible of the accuracy of the information obtained about a client. Furthermore, forensic or legal aspects of the case can appear unexpectedly. It is advisable to be forearmed with data from well-researched and valid measures in the event that the clinician is called to testify in a forensic matter as a treating therapist. It would, of course, represent a likely conflict of interest for one to assume both a clinical practitioner and forensic examiner role in the same case.

In terms of evaluating trauma histories of clients for purely clinical purposes, therapists will generally find clients' memories and interpretations of crime events as or more useful in treatment planning than a factual account of past events, even though the former may be factually inaccurate or irrational. This is because the meaning of a crime to a client often shapes the psychological response more than the actual circumstances.

Strategies for Assessing Experiences and Responses of Crime Victims

Sources of Information

Multiple sources of information are available to victim's assistance providers and mental health professionals who are aiding crime victims. The client is usually the primary source of information about past experiences and current symptoms. Although clients are seldom able to provide completely objective information about themselves and their experiences, they always provide important information about their own perceptions, recollections, and subjective experience of events. Obtaining such subjective information is essential to any assessment of trauma responses. In addition to a standard clinical interview where the clinician gathers information about the presenting problem and psychosocial history, there are several ways to obtain information from crime victims and other potential sources of information about them.

Self-Report Measures and Structured Interviews

Self-report symptom and experience measures and structured interviews have several advantages for the assessment of crime victims. First, they are readily available to clinicians, and they require no special equipment and most require relatively little special training to administer. Compared to other sources of information from clients, more is known about the reliability and validity of self-report measures and interviews, and more information is available about how to interpret results. Lastly,

many self-report measures are inexpensive or cost nothing to use, so they can be useful when resources are limited.

Psychological Tests

Standardized psychological tests can provide useful additional information about responses to crimes, though some cautions are necessary about their use. Commonly used global “personality” and symptom measures such as the PAI, MMPI, and MCMI are certainly useful in providing information about current psychological disorders and personality disorders (Allen, 1994; Briere, 1997). In addition, the MMPI-II, PAI, and the MCMI-III have PTSD subscales that can be used to screen for PTSD. Caution is warranted, however, because results of these subscales may be misleading for clients whose scores fall at lower levels or near the cutoff scores for classification (Gaston, Brunet, Koszycki, & Bradwejn, 1998; Lyons & Wheeler-Cox, 1999). Furthermore, MMPI PTSD subscales are made up of items drawn from the MMPI-2; they do not represent the symptoms of PTSD very completely. For example, there are no items about symptoms of intrusive images or emotional numbing that are commonly associated with posttraumatic responses. The success of the MMPI subscales in identifying those with PTSD has been mixed, and results are not comparable to those obtained by using available brief PTSD screens (Lyons & Wheeler-Cox, 1999; Solomon et al., 1996). The performance of the MCMI-III PTSD subscale in identifying those with PTSD has not yet been firmly established (Hyer, Boyd, Stanger, Davis, & Walters, 1997). While MMPI profile scores were somewhat helpful in differentiating those with PTSD from others, the profile scores of the MMPI-II have not proved so useful (Lyons & Wheeler-Cox, 1999). All in all, use of MMPI or MCMI profiles or PTSD subscale scores may be useful if no other measures are available, but they are inadequate substitutes for specialized measures of PTSD.

Unfortunately, some uses of psychological tests can be problematic when assessing people who have been traumatized by crimes. For example, the MMPI “F” scale has been found to be elevated in those with PTSD (Orr et al., 1990). The F scale was designed to be a validity scale to indicate carelessness in responding, gross eccentricity, or malingering (or “faking bad”), and it was originally made up of items that were thought to be rare psychiatric symptoms (Anastasi, 1988). It turns out that some of those symptoms are common to many with posttraumatic or dissociative disorders, particularly war veterans. For example, F scale items include “I have nightmares every few nights” and “I believe my sins are unpardonable.” Using the MMPI to assess a traumatized person

might lead to the mistaken conclusion that the person is exaggerating his symptoms, when he is actually accurately reporting them. The danger of misinterpretation of an elevated F scale score is very likely present in the MMPI-2 as well as the MMPI, as 60 of the 64 items that load onto the F scale were retained in the MMPI-2 (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989). It is possible that there are similar problems with the MCMI validity scale scores in traumatized people, but no studies are yet available on that question. While MMPI F scale scores must be interpreted cautiously in trauma victims, the more recently developed F(p) scale (Arbisi & Ben-Porath, 1995) may be a useful aid in identifying those whose F scale elevation is due to psychopathology rather than “invalid” responses.

Among projective tests, the Rorschach inkblot test is widely used in clinical assessments. In recent years, there has been increased interest in use of the Rorschach in trauma survivors (Allen, 1994; Briere, 1997; Levin & Reis, 1997). A Traumatic Content Index has been developed and studied that provides information about how a person is responding to a known trauma (Armstrong & Loewenstein, 1990). Results from other projective tests like the Thematic Apperception Test (TAT) or projective drawing tests (like the Draw-A-Person) may provide some interesting and useful clinical hypotheses, but because results from these tests tend to have questionable validity and are usually not objectively scored, they cannot give clear and objective information about PTSD or other crime-related symptoms.

Neuropsychological tests may also be helpful for assessing crime victims, particularly when any type of head injury is involved (Knight, 1997; Wolfe & Charney, 1991). Although neuropsychological tests can provide useful information about cognitive functioning of crime victims, results of studies to date reveal no clear pattern of test results that serves as a marker of trauma-related neuropsychological impairment (Knight, 1997). Those using neuropsychological tests with trauma survivors should be familiar with ways in which posttraumatic symptoms can interact with aspects of test administration and invalidate or alter the results (Knight, 1997).

Alternative Methods for Cases With Impediments to Communication

Because children, especially very young children, may not have the cognitive or verbal skills necessary to describe and explain their experiences and feelings, the clinician may need to use alternative methods to assess children (Lipovsky, 1992). These methods may also prove quite

useful with clients who have developmental disabilities involving impaired intellect or verbal expression. Furthermore, alternative methods may be helpful in cases where the assessor does not speak the same language as the crime victim, and no one is available to translate. This situation can easily occur, given that it is advisable to avoid having a family member serve as a translator, because revealing both the crime experience and its effects on the victim may increase the victim's danger in domestic violence cases or shame and embarrassment when the crime involves stigma as in rape. Unfortunately, the validity of these methods has not been assessed for these populations, so that should be taken into consideration when interpreting the results and evaluating the overall validity of the assessment.

Some of the most common alternative methods used with children include interviews using anatomical dolls, observation of play, and analysis of drawings. These methods are frequently used to gather information from children who might have been sexually assaulted. Unfortunately, relatively little work has been done in this area, so the use of these methods has not been standardized. Consequently, the validity of indicators of trauma in play, drawings, or anatomical doll interviews is uncertain. Lipovsky (1992) cautions that interactions with anatomical dolls or behaviors observed during play cannot be taken at face value. Those evaluating children, and who are interested in these methods, should realize that their use is still quite controversial. Some argue that having a child use anatomical dolls to "act out" what happened may introduce fantasy material into the evaluations. As an alternative, it may be better to use an anatomical doll, a body replica, or line drawings only as an aid to children in identifying body parts. Before using any of these methods, it is advisable to read further about the methods and about alternative ways to assess trauma and trauma-related disorders in children (American Professional Society on the Abuse of Children, 1995c; Everson & Boat, 1994; Katz, Schonfeld, Carter, Leventhal, & Cicchetti, 1995; Koocher et al., 1995; McNally, 1991).

Official Records and Collateral Sources

Gathering information from official records and collateral sources may be useful and advisable under some circumstances. Official records might include records of prior treatment, testing results, medical records, police and court records, military records, school records, and witness statements. An example of the use of official records might be obtaining the medical records of someone who was assaulted. This use of records to corroborate reports is recommended when those seeking compensation re-

lated to a crime, as some of these persons may, for various reasons, misreport or exaggerate their experiences or symptoms (Armstrong & High, 1999; Resnick, 1998). Another example of using official records might be examining school records when evaluating a child to gather information about declines in functioning and disruptive behavior.

Information from collateral sources may provide useful information about a client's current or prior functioning. Such sources may have information that is not available to the client because of cognitive avoidance or denial (Newman et al., 1996). Collateral sources of information might include parents, family, friends, teachers, employers, and former therapists. It is easy to see how interviews with parents or teachers of a child might provide valuable information about the child's behavior. Some clinicians also suggest collateral sources be used to obtain information about adults. For example, Dutton (1992) mentions such interviews as potentially important sources of information about women's experience of domestic violence, although this is likely to be most appropriate for forensic evaluations and in all cases should be done with the their permission and knowledge to avoid increasing their risks. Most therapists will also want to obtain any records relating to prior treatment, though this may raise difficult ethical questions under some circumstances (Dalenberg, in press; Dalenberg & Carlson, in press).

However, use of official records and collateral sources can be a double-edged sword. While they may be indispensable when an evaluation serves a forensic purpose, they may be counterproductive and damaging to the therapeutic relationship when the evaluation is primarily for clinical purposes. Obtaining information from other sources, even with the client's permission, may threaten the client's sense of control, reduce the client's trust, and make the client anxious about her privacy. With the possible exception of past treatment records, this cost may not be worth the benefit obtained. Furthermore, sometimes, it may not be in the client's best interest to question others. Sometimes the questioning has a negative effect on the client. For example, questioning a teacher about a child's behavior might violate the child's privacy and stigmatize the child as disordered.

Lastly, collateral sources may yield information that is difficult or impossible to interpret. Inconsistencies between client reports and reports from collateral sources may indicate that the client's reports are inaccurate, but the inaccuracy may lie in the collateral sources. For example, Lipovsky (1992) noted that parents tend to underestimate emotional impact of sexual abuse on their children. In general, research has found that parents and other observers are poor reporters of children's internalizing symptoms

such as anxiety or depression (Finch & Daugherty, 1993; Putnam, 1996). Clearly some parents might be motivated to underreport or minimize abuse of their children because of guilt over failing to protect their children or because they want to protect the abuser from prosecution. Official records might also be inaccurate, incomplete, or misleading. For example, failure of medical records to show evidence of childhood sexual abuse might give the impression that abuse did not occur. Many times, however, sexual abuse leaves no physical evidence or abused children are not taken to doctors, so abuse goes undocumented. Furthermore, doctors with a low index of suspicion for sexual abuse or little training in examining abuse victims may fail to look for or detect visible indicators of sexual activity in a child. For these reasons, if information from collateral sources is collected, it should not be taken for granted that it is accurate or complete. In sum, reliance on multiple data sources typically is better than on any single source.

Choosing Measures to Fit the Client

There are numerous characteristics of measures that make them more or less suitable for use with a particular crime victim at a particular point in time. Using one or two scales and interviews with all clients has the advantage that seeing numerous examples of responses to the same measure fosters expertise in interpretation of the measure's results. On the other hand, having a wide variety of measures to select from to assess clients with different characteristics has the advantage that more useful information might be obtained about a client by using a measure that is particularly well suited to her.

Comprehension

First and foremost, it is crucial that the client understands the questions that are asked in a scale or structured interview. Ideally, the questions should be asked in the client's first language. Unfortunately, most scales and interviews are only available in English, so assessing clients for whom English is not a first language becomes more challenging. In this situation, it is prudent to administer all measures and interviews verbally, to monitor the client's understanding of language, and to clarify any uncertainties the client has about what words mean. The same method should be used with any clients who have limited reading skills or are illiterate. In such cases, it is important to remember that the validity of the assessment's results are compromised by the different administration method, and the measure's norms probably do not apply to these clients.

It is also important that the level of language used in the scale or interview is appropriate for the cognitive capacities and education level of the client. Certainly, most measures designed for adults would not be well understood by children. The clinician must sometimes make a judgment call as to whether to use a measure designed for children or adults; for example, when assessing an adolescent crime victim, this decision must be based on the intellectual development of the adolescent. When assessing an adult who is retarded or developmentally disabled, an interview designed for children is likely to be more appropriate than one designed for adults.

You will also find that measures in the same domain vary considerably in the level and complexity of language they use to describe symptoms. Many of the measures and interviews available were originally developed as research instruments and are written in fairly complex language that may be difficult for some clients to understand. This issue should be taken into consideration when choosing measures for clients who have less formal education.

Question Content

Level of Insight Required

The level of insight required for answering questions about symptoms should be appropriate for the client. This issue is reflected in a controversy that is related to the structure of the DSM criteria for PTSD. Some of the DSM criteria require that there be a causal relationship between the symptom in question and the traumatic event experienced. For instance, one criterion is that the client experiences intense psychological distress when exposed to cues that symbolize or resemble an aspect of the traumatic event. While the DSM does not specify that the client must recognize the connection, most PTSD measures word items in a way that does require this. The trouble is that if a client did not see a connection between his distress and reminders of a traumatic event, his low score on a measure item would not reflect his actual symptoms. As Solomon and colleagues (1996) point out, it may be preferable to use measures that do not require clients to have this high level of insight.

Gender and Cultural Background

Gender and cultural background may be important issues in the choice of measures. Because the diagnostic criteria for PTSD and the majority of established measures of PTSD were developed with male combat veterans as the primary model for traumatization, it is possible that many

standard assessment instruments do not adequately assess the range of posttraumatic responses manifested in female trauma survivors. For example, problems in the domains of self-esteem, relationships, and identity are common in female trauma survivors, though they are not included in the DSM-IV criteria for PTSD (Carlson, 1997). Wolfe and Kimerling (1997) provide an in-depth discussion of gender issues in the assessment of PTSD and describe aspects of assessment that may require special attention in women. For example, because traumas occurring in the context of ongoing relationships (such as spousal abuse or rape) may not be readily recognized as traumatic stressors, behaviorally specific descriptors and queries are recommended when assessing traumatic events in women (Wolfe & Kimerling, 1997).

Although most scales and interviews were not intentionally designed for clients of any particular cultural background, a large proportion of available measures were developed using middle and upper middle class American subjects as the norm. Consequently, to the extent that a client's cultural background differs from that of middle class America, a scale might be inappropriate for her. This is particularly true of scales and interviews measuring past traumatic experiences. An example of how culture might affect responses to a measure involves administration of a measure of traumatic experiences to a crime victim who was a refugee from Vietnam. The traumas asked about in that measure are unlikely to be those most relevant to the experience of this client. For example, standard U.S. trauma interviews would not inquire about many traumatic experiences common to refugees such as losing all of one's possessions, witnessing torture, or having one's family members disappear or be killed. Further discussion of ethnocultural issues in the assessment of mental disorders can be found in Keane, Kaloupek, and Weathers (1996), Lu, Lim, and Mezzich (1995), and Manson (1997).

One could also argue that some of the symptoms of disorders listed in the DSM-IV are culturally bound. For example, the core responses of reexperiencing and avoidance for PTSD are likely to be manifested in different behaviors in different cultures. For example, in a society where sanctions for violent behavior are extreme, an aggressive response to trauma might be manifested verbally, by angry yelling, rather than physically or it might not be expressed at all. In addition, there are undoubtedly symptoms in other cultures that are manifestations of reexperiencing and avoidance that are not listed in the DSM. The issue of the cultural appropriateness of DSM disorder criteria should be kept in mind when evaluating persons from other cultures. If a client seems to be "missing" some symptoms, it might be possible to find out about symptoms that are taking on a form more appropriate to the

client's culture by asking broad questions. For example, when assessing for PTSD, one might ask "is there any other way that the crime event 'comes back to you'?"

Format of Measure

Self-report measures and structured interviews vary greatly in their characteristics and their usefulness for different purposes. Advantages of self-report measures include that they require very little of the patient's or clinician's time to administer, often cost little or nothing to use, and may yield better disclosure from clients than face-to-face interviews (Newman et al., 1996). These qualities make self-report measures a good choice for a first step in the assessment of traumatic experiences and responses. If a client scores high on a self-report measure, the person should then be administered a structured interview to gather more detailed information. However, if a client does not score high on a self-report measure, it is possible that the client is minimizing his symptoms and that a more detailed, clinician-administered structured interview will be more effective in identifying the client's trauma symptoms.

Advantages of structured interviews include that they provide a systematic way for the clinician to obtain more detailed information about experiences or symptoms, they typically include collection of qualitative information as well as quantitative information, and they allow the clinician to observe the client's interpersonal behavior and affective responses. These qualities make structured interviews particularly useful for obtaining detailed trauma histories and detailed information about symptoms after it has been established that a client has had some sort of crime experience and some related psychological symptoms. It is also highly advisable to conduct structured interviews with any clients who are being evaluated under special circumstances such as for disability compensation, as part of a law suit claiming psychological harm resulting from a crime, or as part of a criminal defense. In such circumstances, the more detailed information obtained from a structured interview will be of much more help in determining the veracity of responses than would the results from self-report measures.

Self-report measures and structured interviews vary considerably in their length and complexity. For example, some self-report measures of PTSD have the client rate both the frequency of PTSD symptoms and the intensity of the symptoms, while others measure only one of these or a combination of the two. The self-report measures that tap both frequency and intensity naturally take longer to complete than those that ask for a single rating. Clinicians

who know they will be unable to conduct a structured interview with a client might prefer to use one of the more complex self-report measures so that they can get as much information about symptoms as possible.

Domains to Assess in Crime Victims

Experiencing a crime, particularly one that is traumatic, can have a very wide range of effects in a person's life. In an ideal world, it would be helpful to assess crime experiences and other possible high magnitude stressors, all of the potential symptoms, and all of the affected domains of a client's life. But realistically, most mental health professionals or victim's assistance workers will not have the time or resources to do this for every client. So it is important to systematically assess the most likely crime and traumatic experiences and the most likely psychological responses. In addition, one should ask about the major secondary and associated symptoms that are typically seen in traumatized crime victims. When a secondary or associated symptom is very prominent, it should also be systematically assessed if a good measure is readily available. It is advisable to gather and have on hand a basic set of measures of crime and trauma experiences, trauma responses, and secondary and associated symptoms.

Assessing Crime and Other Traumatic Experiences

Arguably, some assessment of crime experiences and other high magnitude stressors should be conducted with every client seen. A brief, self-report measure will cost little time or money and yields important information. Knowing about clients' exposure to high magnitude stressors is often critical to understanding their current distress and planning treatment. Clients who have not had been exposed to many high magnitude stressors, will not have to spend much time on the screen at all because they will simply answer "no" to most of the questions.

When it is known that a client has had a particular crime experience, such as a recent rape, it may be tempting to skip this step of the assessment. But this would be a mistake because valuable information about past traumatic experiences that have not been resolved might be missed. Very often, responses to recent traumatic events are exacerbated by unresolved earlier traumatic experiences. As mentioned earlier, previous exposure to a traumatic event increases the likelihood that a person will develop PTSD when exposed to another traumatic stressor (Breslau et al., 1999). Even years after a posttraumatic response has been resolved, it can return in response to stressful or traumatic events that are reminders of the earlier experience (Sonnenberg, 1988).

The National Center for PTSD web site (www.ncptsd.org/treatment/assessment) provides descriptive, reference, and author contact information on published adult and child trauma exposure screens and interviews. In addition, a number of readily available brief screens and interviews for traumatic experiences (including crimes) are described in Carlson (1997), Norris and Riad (1997), Nader (1997), and Solomon et al. (1996). One that those working with crime victims are likely to find particularly useful is the National Women's Study Event History (Resnick, Falsetti, Kilpatrick, & Freedy, 1996). This measure inquires about a wide range of traumatic events, including many that are violent crimes. Detailed probes include queries about number of events, age at first event, time of most recent event, fear of being injured or killed during first or most recent event, and injuries during first or most recent event. Additional probes for the assessment of first, most recent, and worst completed rape experiences and for molestation, attempted sexual assault and physical assault experiences include familiarity with assailant, relationship to assailant, use of drugs or alcohol by subject or assailant, and whether incident was reported to police or authorities.

Assessing Symptoms

Assessing the symptoms of crime victims has two major purposes. The first is to determine the scope and nature of the most prominent psychological responses to the crime; that is, what are the most pressing clinical presenting problems for this client? The second purpose is to determine what other symptoms are also present that need to be addressed or need to be taken into consideration when addressing the primary presenting problems. For example, a person who was stabbed might have a presenting problem of PTSD and also be bothered by depression that was secondary to his inability to work or socialize because of reexperiencing and avoidance symptoms.

Because many crime experiences are sufficiently sudden, uncontrollable, and negative to constitute a traumatic stressor, PTSD and dissociation symptoms are important outcomes to assess. When a person has been traumatized, PTSD and dissociative symptoms are the most useful symptoms for distinguishing between posttraumatic reactions and other disorders, because they seem to be uniquely related to the experience of trauma (Carlson et al., 2001; Carlson & Rosser-Hogan, 1991). In cases that involve deaths of person important to the client or other significant losses (e.g., loss of home to arson by abuser; disfigurement by rapist using weapons), it is also important to assess symptoms of traumatic or complicated grief (Shear & Smith-Caroff, 2002).

When a crime is a traumatic stressor, there are also a number of other symptoms that can be secondary to PTSD or associated with the trauma. Secondary responses are a “second wave” of symptoms that occur following trauma as a result of initial symptoms of reexperiencing and avoidance. They are indirectly, not directly, caused by the overwhelming fear that occurred at the time of trauma. Associated responses are also not directly related to being overwhelmed with fear: they are caused or shaped by the social environment or other circumstances accompanying or following the trauma. Common secondary and associated symptoms include depression, aggression, anxiety, substance abuse, physical illnesses, low self-esteem, identity confusion, difficulties in interpersonal relationships, and guilt or shame.

Many of these symptoms can also result from crimes that are not traumatic stressors when the negative meaning of a crime impairs trust, beliefs in a benevolent world, and feelings of self-worth. For example, a person may be the victim of a financial fraud and not experience the sudden and overwhelming fear, helplessness, or horror that characterize traumatic stressors. But the person may still lose faith in people and become depressed over the financial loss. Depression, anxiety, and anger are common responses to crimes that are not traumatic stressors, and these symptoms should be inquired about and specifically assessed if present.

PTSD and Dissociation Symptoms

Because PTSD symptoms are fundamental to trauma responses, this is a very important domain to assess when evaluating crime victims. Although research on dissociation symptoms is not nearly so extensive as that on PTSD symptoms, studies to date have shown that there is a clear relationship between traumatic experiences and later reports of dissociative symptoms (Putnam & Carlson, 1998). While extreme forms of identity dissociation such as those observed in dissociative disorders are relatively rare, less severe dissociative symptoms are commonly reported by trauma survivors (Putnam, 1995). Posttraumatic dissociation most commonly takes the form of depersonalization (defined as distortions in perceptions of oneself), derealization (defined as distortions in perceptions of one's environment), and gaps in awareness. Although dissociative symptoms are frequently discussed as though they are distinct from PTSD and are not well described in the diagnostic criteria nor well-assessed by most PTSD measures and interviews symptoms, they are arguably an integral part of posttraumatic responses (Carlson & Dalenberg, 2000). Support for this notion is provided by the inclusion of dissociative symptoms as prominent features of Acute

Stress Disorder, a diagnosis assigned to those who have dissociative, reexperiencing, avoidance, and hyperarousal symptoms following a trauma, but who do not yet qualify for the 1 month duration criteria for PTSD.

Measuring dissociation can yield valuable clinical information about a person's response to trauma that will not be available from a PTSD scale or interview. Such information about dissociation symptoms may be useful in treatment. For example, results of a dissociation measure may help identify a client's most commonly employed cognitive avoidance strategies and may detect disturbances in memory and identity. For this reason, it is advisable to measure dissociation for all clients who report past traumatic experiences or who show high levels of PTSD symptoms. It is important to be cautious, however, in interpreting high levels of dissociation in persons who report low levels of PTSD, because it is possible to have a relatively high level of nonpathological dissociation with no history of trauma (Carlson et al., 1993).

There are several good sources of information about measures of PTSD and dissociation symptoms. The National Center for PTSD web site (www.ncptsd.org/treatment/assessment) provides descriptive, reference, and author contact information on adult and child self-report and interview measures of PTSD. Briere (1997) focuses on clinical assessment of posttraumatic states in adults, includes critical reviews of specialized posttraumatic symptom measures, and discusses use of psychological tests in assessing trauma victims. Carlson (1997) focuses on clinical assessment of traumatic experiences and posttraumatic responses in children and adults and includes profiles of numerous recommended scales and interviews. The measure profiles describe the characteristics and appropriate uses of the instruments along with addresses for obtaining each measure. Solomon et al. (1996) critically reviews self-report measures of PTSD for use in research settings while Newman et al. (1996) reviews measures of PTSD for use in both research and clinical settings. Wilson and Keane (1997) contains a chapter that reviews measures of trauma and PTSD (Norris & Riad, 1997) and several chapters that focus on specific measures of posttraumatic symptoms. Also included are chapters on assessing responses to traumatic experiences in children (Nader, 1997), assessing PTSD in couples and families (Wilson & Kurtz, 1997), and assessing traumatic bereavement and PTSD (Raphael & Martinek, 1997). Stamm (1996) is a compendium of profiles of trauma and trauma response measures mostly written by the authors of the measures. The profiles vary greatly in the amount of information provided and some include the measures themselves. This book includes some measures that have not yet been validated and are not critically reviewed.

Although most of the PTSD scales and interviews described in these sources are based on the DSM symptoms of PTSD, the measures differ in some important ways. In keeping with the “single trauma” model of the DSM, many measures of PTSD specifically inquire about symptoms related to a single traumatic event. This may limit their usefulness with persons who have had multiple traumatic experiences. Also, some measures that are keyed closely to the DSM criteria for PTSD begin with a screening question for Criterion A. If the client does not report such an experience, no further questions about symptoms are asked. Many clinicians find this method to be undesirable because a client may interpret the question too narrowly, erroneously denying having had a traumatic experience. Furthermore, some measures use the stressor criterion from DSM-III-R which defines a traumatic event as one “outside the range of usual human experience” that would be “markedly distressing to almost anyone.” Because this criterion is now thought to be a poor definition of a traumatic stressor, measures that use it may be less useful. There is also a good deal of variation in the language measures use to describe symptoms, the length and complexity of the measure, and the requirement that the client connect her symptoms to the traumatic experience.

On the other hand, a measure of PTSD in which symptoms are keyed to a single event may be useful when it is necessary to evaluate whether a person’s PTSD symptoms are related to a particular crime. Unfortunately, when clients have histories of multiple traumatic events or when the event in question occurred long ago, it may be difficult or impossible for clients or clinicians to unequivocally determine that a particular symptom is related to a particular event. This too has been said before.

Traumatic Grief

Witnessing a death during a crime or learning of the crime-related death of a loved one can both meet criteria for a traumatic stressor in the DSM-IV system, and studies of those with such losses have shown elevated levels of posttraumatic symptoms such as reexperiencing, avoidance, hyperarousal, and dissociation (Shear & Smith-Caroff, 2002). Clinicians and researchers interested in bereavement have increasingly begun to consider whether the grief responses of some, particularly those who lose loved ones suddenly and through violent deaths, are at risk for a distinctive type of grief response that has been referred to as traumatic grief or complicated grief. Two groups have developed sets of diagnostic criteria for complicated grief that include symptoms of intrusions related to the deceased, periods of unusually strong

emotion related to the loss, excessive yearning or searching for the deceased, excessive feelings of loneliness or emptiness, avoidance of reminders of the deceased, sleep disturbances, loss of interest in activities, a sense of purposelessness or futility, emotional numbness or detachment, difficulty acknowledging the death, feelings that life is meaningless or that part of oneself has died, a shattered world view, development of symptoms or harmful behaviors of the deceased, and excessive irritability, bitterness, or anger about the death (Horowitz et al., 1997; Prigerson & Jacobs, 2001). While it is as yet unclear whether such grief responses are best conceptualized as a form of PTSD, a form of major depression, or as a disordered form of bereavement, it appears that such responses do routinely occur following violent deaths, that the clinical presentation includes symptoms that are not included in the symptom criteria for PTSD or major depression, and that these conditions can be persistent and quite debilitating. For these reasons, it is advisable to inquire about symptoms of disordered grief in clients who are survivors of crime-related deaths. Discussion of assessment of traumatic grief is available in Raphael and Martinek (1997), and a recent, carefully validated measure of complicated grief was described by Prigerson and Jacobs (2001).

Secondary, Associated, and Other Symptoms

Symptoms that may be secondary to a posttraumatic response to a crime, associated with a traumatic crime event, or the result of a nontraumatic crime event include: depression, aggression, anxiety, substance abuse, physical illnesses, low self-esteem, identity confusion, difficulties in interpersonal relationships, and guilt or shame. All of these symptoms should be assessed in detail if preliminary inquiries about them in clinical interviews indicate that they are a problem. Identifying symptoms as primary, secondary, or associated can be useful clinically because it might provide insight about the causality of symptoms and might lead to different treatment approaches. For example, if a client shows aggressive behavior that is a primary response to trauma (a form of reexperiencing), it might be best addressed with a behavioral intervention aimed at extinction. On the other hand, if a client’s aggressive behavior is a secondary symptom (acquired through social learning in a violent environment), it might be best addressed with social skills training.

Some aspects of depression are actually measured by PTSD scales and interviews, including decreases in interest in former activities, lack of hope about the future, sleep problems, and trouble concentrating. But other important depression symptoms are not, such as depressed mood, feelings of worthlessness or excessive guilt, psychomotor

agitation or retardation, weight gain or loss, fatigue, or suicidality. For this reason, if after a preliminary inquiry, there is any sign of depression, it is important to assess a client's level of depression using some standard measure of depression such as the Beck Depression Inventory (Beck & Steer, 1993) or depression subscales of the MCMI (Millon, 1994) or the SCL-90-R (Derogatis, 1983).

Symptoms of anger and aggression following crimes might be manifested as anger or aggression toward others or toward oneself. Measuring aggression toward others is difficult because of limited development of measures in this domain and because social stigma attached to aggression and lack of insight about anger and aggressive impulses may limit the usefulness of self-reports for some individuals. Some measures that might yield useful information about aggression include the State-Trait Anger Inventory (STAXI, Spielberger, 1985), the Multidimensional Anger Inventory (Miller, Jenkins, Kaplan, & Salonen, 1995), the Conflict Tactics Scale (Straus, 1979), and the Hostility subscale of the SCL-90-R (Derogatis, 1983).

Aggression toward oneself can be expressed by a number of different forms of self-destructive behavior including suicidality, self-harming behaviors, substance abuse, sexual impulsiveness, reckless behavior, and disordered eating. Many authors have noted the importance of assessing trauma victims for suicidality (Dutton, 1992). Standard methods or measures of suicidality should serve for this purpose. It is a bit more challenging to measure the entire range of self-destructive behaviors. Gil (1988) offered suggestions for questions to evaluate self-harming behaviors, substance abuse, and disordered eating in traumatized people.

Anxiety that is secondary to a posttraumatic response or associated with a crime event or the result of a nontraumatic crime may be very difficult to differentiate from the anxiety symptoms of PTSD. Using a separate measure of anxiety will probably not be of much assistance, but discussing a client's anxiety and exploring its roots may. A different treatment strategy is often needed for anxiety that is a primary posttraumatic response compared to anxiety that is secondary, associated, or resulting from a nontraumatic crime.

Substance abuse is a very common symptom following traumatic crimes. Substance use can be secondary to PTSD when crime victims "self-medicate" their posttraumatic symptoms. It can be associated with a crime when a crime occurs in a situation involving drug use, such as when an intoxicated homeless man is a crime victim. Because many clients use substances, particularly alcohol, it can be difficult to gauge when substance use has become problematic. Many brief screens are available that can help a clinician make such a determination. Two readily avail-

able and popular screens include the CAGE (Mayfield, McLeod, & Hall, 1974) and the TWEAK (Russell et al., 1991).

Guilt and shame can be secondary to crime-related PTSD. For example, when PTSD symptoms interfere with a person's social or occupational functioning, the crime victim may feel guilty over not living up to family or work responsibilities. As an associated symptom, guilt or shame can occur when a client has regrets over things he "should have done" or "should not have done" at the time of the crime. The Trauma-Related Guilt Inventory can be as useful tool for assessing guilt following a traumatic crime (Kubany et al., 1996).

Other secondary and associated symptoms include physical illnesses, low self-esteem, disturbances in identity, and problems with interpersonal relationships. Brief measures that relate these symptoms to traumatic events are not available. Asking about these responses at some point in the assessment is likely to yield valuable information about the effects of initial responses to crimes and the crime situation on your client's functioning.

It is also clinically useful to assess the meaning of a crime to an individual and the impact of that meaning on their views of the world, others, and the self. Information about meaning and its impact can help the clinician determine which meaning issues are unresolved for a particular client. Measures that may be useful for this purpose include a brief, self-report scale that assesses basic assumptions about the world, others, and the self (Janoff-Bulman, 1989) and a detailed semistructured interview that assesses conflict about fifteen themes that relate to the meaning of an event (Newman et al., 1997).

Assessment of crime victims should also include the consideration of other psychological disorders. Research has shown that people who meet criteria for PTSD also often meet criteria for a number of other psychological disorders (Keane & Wolfe, 1990). Whether these disorders preceded the trauma or developed secondary to it, they will interact with a trauma response and require consideration during treatment. Personality disorders that are diagnosed on Axis II of the DSM are especially important because they may affect the presentation of a trauma-related disorder. Whether Axis II personality disorders might also be traumatic in etiology or whether they simply cooccur with trauma-related disorders, they are likely to have a considerable impact on interpretation of assessment results and treatment planning. Comorbid conditions may occur because traumatized persons are at greater risk for developing psychological disorders and because those with psychological disorders are at greater risk for being traumatized after a highly stressful event. Consideration of the possible etiology of comorbid disorders is important

because symptoms with different causes may require different treatment approaches.

Conducting Therapeutic Assessments of Crime Victims

Talking about traumatic events and psychiatric symptoms can be a very stressful experience. Clinicians can, however, reduce clients' distress and even make an assessment somewhat therapeutic. To allow clients to make informed choices about participation in an assessment and to reduce anxiety about what will be happening, the assessment process should be explained in detail before beginning. This is important because lack of controllability of a crime experience can play a key role in the development of posttraumatic responses and make clients anxious about lack of control during a trauma assessment.

For these reasons, clients should be given some control over the pace of an interview and encouraged to speak up if they feel overwhelmed or would rather not answer a question. Occasionally, clients become very disturbed when uncovering traumatic memories so that it is not possible to probe for details during the initial assessment (Litz & Weathers, 1994). Special caution is advisable with clients who appear psychologically fragile or deteriorating as such clients may decompensate if stressed too much. Clinicians must also be sensitive to nonverbal signs of discomfort because some clients may be very compliant, even expressing willingness to go on with an interview despite distress. Many clients with severe trauma histories have trouble monitoring their own distress or knowing how much distress is too much. Taking a break or stopping a line of questioning because the client is becoming overwhelmed will help clients learn how to interrupt escalating anxiety.

If a client asks to take a break or stop the interview, clinicians can reinforce such self-protective coping behavior by explicitly pointing it out as an effective way to increase feelings of control. At the same time, it is a good idea to ask the client for permission to come back to the question or topic later and to explain that avoidance of the upsetting aspects of a crime experience is not a good long-term strategy, even if it is a wise choice in the short term. Clients whose avoidance of traumatic material is predominant should be informed of the role of avoidance in posttraumatic stress responses and the impediment such avoidance may be to progress in treatment.

It is important to be certain, however, that stopping an interview is in the client's best interests and not in response to the therapists' discomfort with the client's strong affect. Because listening to clients recount traumatic experiences can be very distressing, clinicians may

feel impelled to protect themselves emotionally and inadvertently give clients the message that they have heard enough. Resick and Schnicke (1993) caution clinicians to avoid overreacting when they are told about crime experiences. Becoming visibly upset or appearing alarmed when a client becomes upset may give a client the impression that the clinician thinks the experience is insurmountable or cannot handle hearing about what happened to her. Rushing to give a client a tissue may be seen as a message to "pull herself together" and stop crying. Regardless of the reasons for such behaviors, it is as important to avoid prematurely cutting off clients' account as it is to avoid allowing them to continue too long. In addition to stifling the clients' openness and reducing the amount of clinical information obtained, such reactions can make clients feel alienated and discourage them from pursuing treatment. In contrast, it can be very reassuring to a client to be told that he is not overreacting to a crime experience nor is he "going crazy." Such support provided by a clinician can be a powerful ameliorating influence for crime victims.

If a client continues to directly or indirectly avoid traumatic material, that may mean that she is not willing or not yet ready or able to discuss these details. It is important to remember that some clients may not be emotionally prepared to explore trauma-related issues (Pearlman & McCann, 1994), and others, particularly those who feel violated by a crime, may be reluctant to disclose intimate details of events or their emotional responses until they have developed a trusting relationship with a clinician. Still other clients are unable to verbalize their experience because they are so emotionally numb or withdrawn. As long as the purpose of the evaluation is clinical and not forensic, you can usually put off gathering details of crime experiences until later in treatment. Although it may be undesirable, you may sometimes have to proceed with treatment recommendations when you have incomplete information about a client's traumatic experiences.

Toward the end of the assessment process, it is beneficial to clients to point out some of their strengths and successes in coping with their crime experiences (Dutton, 1992; Herman, 1992). Many crime victims are to be congratulated on their fortitude for surviving a traumatic experience and remaining as emotionally intact as they have. Highlighting this strength can help reduce the feelings of helplessness and hopelessness that are common following crime victimization.

Conclusion

A large assortment of measures are available that are useful in assessing the experiences and symptoms of crime

victims. Clinicians can keep abreast of developments and innovations in assessment of trauma and trauma responses through resources such as the National Center for PTSD web site (www.ncptsd.org/treatment/assessment), this journal, the PILOTS database, and the annual meeting of the International Society for Traumatic Stress Studies (www.istss.org). The PILOTS electronic database is devoted entirely to the literature on traumatic stress and can be searched via the Internet (www.ncptsd.org/research/pilots/index.html) at no cost to find publications about the development of measures or for publications of studies using particular measures. A guide to using the database is available in Lerner (1996) and specific instructions for searching PILOTS for studies using a particular measure can be found at (www.ncptsd.org/treatment/assessment/assessment-pilots.html). These resources provide access to a rapidly expanding assortment of measures that will be invaluable to those assessing crime victims.

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